National Center for Post-Traumatic Stress Disorder

Summer 1999, Volume 8, Issue 3, ISSN-1052-7168

Clinical Quarterly

Menlo Park/Palo Alto • Boston • Honolulu • West Haven • White River Junction

Seeking Safety: A New Cognitive-Behavioral Therapy for PTSD and Substance Abuse

LISA M. NAJAVITS, PH.D.

Lisa M. Najavits, Ph.D.

Over the past decade, an emerging body of work has documented a very strong association between PTSD and substance abuse. Indeed, most women and many men in substance abuse treatment have a history of trauma, and rates of current PTSD range from 12% to 59% (1-4). Among people with PTSD, rates of substance abuse are also high (5-7). Moreover, the disorders have consistently been found to co-occur across various types of traumas (8) and substances (9). Historically, the connection between PTSD and substance abuse was first emphasized in VA settings with male combat veterans after the Vietnam War (8). Later, studies of civilian populations documented high rates, particularly among females who endured childhood physical and/or sexual abuse (2).

Aside from numbers, the suffering associated with this dual diagnosis is extraordinary, with multiple co-existing life problems, vulnerability to repeated trauma, and difficulties in treatment. Studies that have compared patients with PTSD and substance abuse to patients with substance abuse alone, for example, have consistently found the former more impaired, including more co-morbid Axis I disorders, particularly mood and anxiety disorders, Axis II disorders, medical problems, psychological symptoms, inpatient admissions, and interpersonal problems; and lower global level of functioning, compliance with aftercare, and motivation for treatment (1, 9-12). Life problems are often very severe, including homelessness, HIV, domestic violence, and loss of custody of ones children (2, 3).

In 1993, I began developing a cognitive-behavioral therapy to address this dual diagnosis under a grant from the NIDA Behavioral Therapies Development Program. At that point, there had not been a single published treatment study on this population, nor any psychosocial treatment that had undergone empirical evaluation. Through repeated trial-and-error, the treatment Seeking Safety (13, 14) was developed while simultaneously testing its impact on a pilot sample of women with PTSD and substance dependence. In developing the treatment, the major influences on my thinking were works by Herman (15), Marlatt and Gordon (16), Beck and colleagues (17), Miller (18), Frankl (19), as well as educational research (20).

The treatment is currently being empirically evaluated in samples from six populations: a Palo Alto VA sample of male combat veterans; homeless women; inner-city cocaine-addicted women; adolescent females; incarcerated women; and outpatient women. A description of the treatment, its initial empirical results, and an in-depth example of one session follow.

The title of the treatment... "Seeking Safety" expresses its philosophy: when a person has both active substance abuse and PTSD, the most urgent clinical need is to establish safety.

TREATMENT OVERVIEW

Summary of the treatment. Seeking Safety is a 25-session treatment based on five key principles.

(1) Safety as the priority of this "first stage" treatment.

The title of the treatment, "Seeking Safety", expresses its basic philosophy. That is, when a person has both active substance abuse and PTSD, the most urgent clinical need is to establish safety. Safety is an umbrella term that signifies various elements: discontinuing substance use, reducing suicidality, minimizing exposure to HIV risk, letting go of dangerous relationships (such as domestic abuse and drug using "friends"), gaining control over extreme symptoms such as dissociation, and stopping self-harm behaviors such as cutting. Many of these are self-destructive behaviors that re-

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FROM THE EDITOR...

The 1988 National Vietnam Veterans Readjustment Study (1) reported that almost 75% of male veterans with PTSD had a lifetime alcohol abuse/dependence disorder. A more recent study (2) reported that 44% of veterans seeking outpatient treatment met met the criteria for alcohol abuse/dependence. Dually diagnosed veterans are plagued by numerous problems. They are less likely to be employed, less likely to be married, are more socially isolated, more prone to violence, and, not surprisingly, report low levels of overall physical and mental well-being.

Six years ago, it wasn't uncommon to hear the question, "which disorder do we treat first, PTSD or Alcohol Abuse?" however, there are now programs in development to treat PTSD/Alcohol Abuse co-morbidity concurrently, that is, to address the interactive factors between the two disorders. Several scientist-practitioners have begun to report preliminary data on PTSD and alcohol comorbidity treatment efficacy. Lisa Najavits and her colleagues have developed a manualized treatment and are evaluating their 25 session program in six populations, including male combat veterans, homeless women, cocaine-addicted women, adolescent females,incarcerated women, and women in outpatient treatment. Beverly Donovan and Edgardo Padin-Rivera have developed a 12-week treatment program to addressPTSD and substance abuse. Preliminary data suggest that both programs offer promising systematic and comprehensive treatment. We are very pleased to have these leading experts report this important work in this issue of the Clinical Quarterly.

Malingering occurs when an individual intentionally produces false psychological symptoms. In a litigious society such as ours, it is likely at some point in clinical practice to provide treatment to a client who is also a claimant or to be called upon to conduct a forensic evaluation. From either a clinical or legal perspective, differentiating faked from actual symptoms can be difficult for even the most astute clinicians. In "Guidelines for Differentiating Malingering from PTSD," Judith Armstrong and James High draw upon their extensive clincial and forensic experience to delineate common misconceptions about malingerers and key strategies to minimize the possibility of deception.

Articles from back issues continue to be posted on our website **www.dartmouth.edu/dms/ptsd/** Your comments about the Clinical Quarterly are appreciated and suggestions for future topics are always welcomed.

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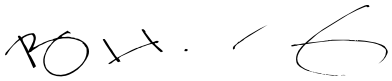

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enact trauma (particularly for victims of childhood abuse, who represent a large segment of people with this dual diagnosis (2)). The concept of first-stage treatment as stabilization and safety has been consistently recommended separately in both the PTSD (15) and substance abuse clinical literatures (21). Later stages of treatment include mourning (a.k.a. exposure therapy (22)) and reconnection (15). In Seeking Safety, safety is taught through a wide range of Safe Coping Skills, asking patients to become conscious of their decisions via a Safe Coping Sheet, setting a Safety Plan, and a report of unsafe behaviors at each session, for example.

II. Integrated treatment of PTSD and substance abuse.

Seeking Safety is designed to treat PTSD and substance abuse at the same time. An integrated model is consistently recommended by clinicians and researchers as more likely to succeed, more sensitive to patient needs, and more cost-effective (9, 10, 12, 23-25). Indeed, a recent survey of patients with this dual diagnosis found that they also prefer simultaneous treatment of both disorders (26). Currently many treatment systems for substance abuse and mental health remain separate, which often leaves the patient to integrate treatment for themselves. One of my patients reported that she had to lie to get into a PTSD treatment program because it did not admit active substance abusers. Indeed, most settings do not treat the two disorders simultaneously (23, 24).

It is important to note, however, that "integration" in Seeking Safety means attention to both disorders in the present. It does not mean asking the patient to talk in detail about the past, which in the stage conceptualization described above, would be "second stage" treatment. Despite the known efficacy of exposure therapy for PTSD (27), numerous experts have recommended that for substance abusers, such work not begin until they have achieved a period of stable abstinence and functionality (25, 28, 29). The concern is that if patients are overwhelmed by painful feelings about the past, this could trigger substance abuse as a misguided attempt to cope. In Seeking Safety, integrated treatment thus means helping patients learn about the two disorders and why they so frequently co-occur; teaching safe coping skills to decrease current symptoms of both PTSD and substance abuse; repeatedly exploring the relationship between the two disorders in the present (e.g., using crack last week to cope with PTSD flashbacks); and helping patients understand that healing from each disorder requires attention to both disorders.

III. A focus on ideals.

It is difficult to imagine two mental disorders that each individually, and especially in combination, lead to such demoralization and loss of ideals. Thus, this treatment seeks to instill countervailing humanistic themes to restore patients' feelings of potential for a better future. The title of each session is framed as a positive ideal, one that is the opposite of some pathological characteristic of PTSD and substance abuse. Thus, for example, the session Honesty combats denial, lying, and the "false self". The session Commitment is the opposite of irresponsibility and impulsivity. The session Taking Good Care of Yourself is a solution for the bodily self-neglect of PTSD and substance abuse. The language throughout the treatment emphasizes values such as "respect", "care", "integration", and "healing". By aiming for what can be, the hope is that patients can summon the motivation for the incredibly hard work of recovery from both disorders.

IV. Four content areas: cognitive, behavioral, interpersonal, and case management.

While originally designed as a cognitive-behavioral intervention (a theoretical orientation that appears well-suited for first-stage stabilization treatment), the treatment was eventually expanded to include equally strong attention to interpersonal and case management issues. Interpersonal sessions now comprise a third of the sessions and case management is begun in the first session and addressed at every session throughout the treatment. The interpersonal domain is an area of special need because PTSD most commonly arises from traumas inflicted by others, both for women and men (6). Whether childhood physical or sexual abuse, combat, or crime victimization, all have an interpersonal valence that raises issues such as whether to trust others, confusion over what can be expected in relationships, and the need to avoid reenactments of abusive power (15) both as victims and perpetrators. Similarly, substance abuse is often precipitated and perpetuated by relationships: many patients grew up in homes with substance-abusing family members, and substance use may be an attempt to gain acceptance by others, manage interpersonal conflict. The case management component of the treatment was added to help patients obtain necessary help with life problems such as housing, job counseling, HIV testing, domestic violence, childcare, and other typical difficulties.

V. Attention to therapist processes.

Research shows that for substance abuse patients in particular (and psychotherapy in general), the effectiveness of treatment is determined as much or more by the therapist as by any particular theoretical orientation or patient characteristics (30). With this dual diagnosis population, who are often considered "difficult", "severe", or "extreme" (9), it is a major challenge to provide effective therapy.

Therapist processes emphasized in Seeking Safety include: building an alliance, compassion for patients' experience; attempting to use the various coping skills in one's own life (not asking the patient to do things that one cannot do oneself); giving patients control whenever possible (as personal control was typically taken away as part of trauma and lost to substance abuse); meeting the patient more than halfway (e.g., "heroically" doing anything possible within professional bounds to

help the patient get better); and obtaining feedback from patients about how they really feel about the treatment. The flip side of such positive therapist processes are countertransference issues that can detract from effective treatment. Indeed, the more severe the patient, the more likely that countertransference may get in the way of the work (31). This includes: harsh confrontation in which the therapist insists on her/his own point of view, sadism, inability to hold patients accountable due to misguided sympathy, becoming "victim" to the patient's abusiveness, power struggles, and, in group treatment, allowing a patient to be scapegoated.

Session topics and format

Examples of session topics are: *Honesty; Asking for Help; Compassion; Taking Good Care of Yourself; Creating Meaning; Setting Boundaries in Relationships; Commitment; Healthy Relationships; Detaching From Emotional Pain (Grounding); Getting Others to Support Your Recovery; Integrating the Split Self; Self-Nurturing; Protecting Yourself From HIV; and PTSD: Taking Back Your Power.* The treatment has been conducted in a variety of formats thus far, including group and individual, open and closed group, 50 and 90-minute sessions, singly and co-led, and outpatient and residential. Its empirical testing, however, was a closed group meeting twice weekly for 12 weeks with 1.5 hour sessions by a single leader.

A typical session

The session begins with a check-in comprised of five questions: Since the last session, *"How are you feeling?"*, *"What good coping have you done?", "Describe your substance use and any other unsafe behavior", "Did you complete your Commitment"*, and *"Case management update"*. (See below for a description of Commitments). Next, an inspiring quotation is read aloud; for example, in the session on PTSD the quotation is from Jesse Jackson, "You are not responsible for being down, but you are responsible for getting up." Most of the session is then devoted to the topic of the session, with emphasis on relating the material to current and specific problems patients are experiencing. Strategies to achieve this include role-plays, experiential exercises, discussion, and the use of a Safe Coping Sheet that guides patients to contrast their "old way" of coping with a "new way" that is safe. Throughout the treatment, patients are encouraged to identify ways that they can cope safely with any life situations that arise. They can draw from a list of over 80 Safe Coping Skills and are encouraged to discover which ones work for them. Two essential process themes are giving the patient control whenever possible (to counteract the inherent loss of control associated with both trauma and substance abuse): the promotion of honesty (to counteract the secrecy and lying typically characteristic of both trauma and substance abuse) and the balanced provision of patient praise (positive reinforcement) and holding patients' accountable (pushing patients to adhere to high standards of behavior to move their lives forward). To close the session, a check-out is conducted in which patients are asked to *"Name one thing you got out of today's session"* (an educational device to reinforce learning as well as give the therapist feedback), and "*Name one Commitment you will complete before the next session*". A Commitment is a between-session assignment that can be any positive, specific step to move forward in one's life (e.g., *"Try calling a hotline to ask for support when you are feeling overwhelmed one time this week"*). Patients can also select from a variety of written options if they choose (e.g., *"Imagine that you are being interviewed for a TV documentary about what helped you to survive so far… What would you say?"*).

Examples of session topics are:
Honesty; Asking for Help; Compassion; Taking Good Care of Yourself; Creating Meaning; Setting Boundaries in Relationships; and Integrating the Split Self.

Empirical results

Thus far, one published study reports results for the Seeking Safety treatment (32). It was conducted in a group format, enrolling a total of 27 women of which 17 (63%) completed the minimum-dose of six sessions. All patients met current DSM-IV criteria for both PTSD and substance dependence. In addition, 65% of patients met criteria for one or more personality disorders. It is important to note that most of the patients in the study had a history of early and repetitive childhood physical and/or sexual abuse, which as later became clear from research reports, represents the majority of women with this dual diagnosis (2). Results were obtained on the 17 patients who met the minimum dose of six sessions as the intent of this initial study was to assess the impact of the treatment on them. Patients attended an average of 67% of available sessions. Based on assessments at pre-treatment, during treatment, post-treatment, and at 3-month follow-up, results showed significant improvements in substance use, trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use, and didactic knowledge related to the treatment. Patients' alliance and satisfaction with treatment were very high. Interestingly, the 17 patients who met the minimum dose of treatment were more impaired than dropouts on a wide variety of measures, yet also more engaged in the treatment. All results are clearly tentative, however, due to the lack of a control group, multiple statistical comparisons, and the absence of assessment of dropouts.

Example of a session sheet

To provide a feel for the treatment, an excerpt from a session sheet is provided below. In each session, the therapist is provided with a Therapist Guide that offers background on the topic, goals, strategies on how to conduct the session, clinical notes, and "tough cases" that may come up. Patients are provided with a session sheet that summarizes the main points in the session and offers ideas for Commitments. The session "Creating Meaning" is designed to help patients explore assumptions that are common among patients who have the

dual diagnosis of PTSD and substance abuse. Examples of some of these beliefs (13) are presented in Table 1.

Future work. Despite the initial promise of Seeking Safety, it is clearly in an early stage of development. Future research, some of which is currently underway, includes the need to study the treatment in randomized controlled trials, to compare and/or combine it with existing treatments for PTSD (e.g., exposure) and substance abuse (e.g., relapse prevention), and to study its generalizability to a wide range of patients, clinicians, and settings.

Table 1. Excerpt from session sheet on Creating Meaning.

MEANINGS THAT *HARM*	EXAMPLES	MEANINGS THAT *HEAL*
Deprivation Reasoning. Because you have suffered a lot, you need substances (or other self-destructive behavior).	*--I've had a hard time, so I'm entitled to get high. --I've had a hard time, so I'm entitled to get high. --If you went through whi I did, you'd cut your arm too.*	**Live Well.** A happy, functional life will make up for your suffering far more than will hurting yourself. Focus on positive steps to make your life better.
I'm Crazy. You believe that you shouldn't feel the way you do.	*--I shouldn't want to get high. --I must be crazy to be feeling this upset.*	**Honor Your Feelings.** You are not crazy. Your feelings make sense in light of what you have been through. You can get over them by talking about them and learning to cope with them.
Time Warp. Your sense of time is distorted, believing that a negative feeling will go on forever..	*--This craving won't stop. --If I were to cry, I would never stop.*	**Observe Real Time.** Take a clock and time how long it really lasts. Negative feelings will usually subside after a while; often they will go away sooner if you distract with activities.
Beating Yourself Up. In your mind, you yell at yourelf and put yourself down.	*--I'm a bad person. --My family was right: I'm worthless.*	**Love--Not Hate--Creates Change.** Beating yourself up may echo what others in the past have yelled at you. But it does not change your behavior; in fact, it makes you less likely to change. Care and understanding promote real change.

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Guidelines for Differentiating Malingering from PTSD

JUDITH G. ARMSTRONG, PH.D. & JAMES R. HIGH, M.D.

Judith Armstrong, Ph.D.

"Iron Mike" came as a forensic referral two years after an accident in which he was slightly injured. Shortly after, a treating physician declared him permanently disabled by "soft" neurologic symptoms. A month later he was hospitalized for anxiety, depression, and psychotic-like behavior. In the hospital he reported that before his accident he had begun seeing rifle-carrying Viet Cong. He said that since the accident he suffered "flashbacks" of a painful Vietnam combat experience that earned him his nickname. He expressed horror and guilt at reliving his terror and his buddy's gruesome death. This memory was related with great catharsis, after which his diagnosis was changed from Adjustment Disorder to Post-Traumatic Stress Disorder. However, he began exhibiting more neurologic symptoms, necessitating re-evaluation. The neurologist's findings were inconsistent with true brain damage. Some symptoms, including transient paralysis, appeared conversion-like, while others, including "volitional" nystagmus, were intentional. Nevertheless this doctor diagnosed "Post-Concussion Syndrome."

It was tempting to dismiss "Iron Mike's" clinical picture as Malingering, the intentional production of false symptoms motivated by external incentives. His symptoms and disability far exceeded objective findings. Some were intentionally produced. Furthermore, he would receive a great deal of money from his lawsuit were his symptoms believed. Yet, he had been declared permanently disabled before he developed these symptoms, and he reported his "flashbacks" as beginning shortly before the accident, suggesting a prior active PTSD. An alternative to Malingering is Factitious Disorder. This also involves the intentional production of false symptoms, but is motivated by the compulsion to assume a sick role. "Iron Mike's" combat history, flashbacks, and pseudo-neurological symptoms occurred in a medical setting, eliciting both medical attention and sympathy. However, he was already accepted as very sick. His symptoms did little to enhance this perception. Finally, Conversion Disorder deriving from a core of mild brain damage and PTSD was possible. A combat veteran with latent, chronic PTSD could experience conversion symptoms following a concussion from a recent frightening accident that re-awakened trauma. However, conversion would not explain Mike's intentionally produced symptoms.

PTSD implies a definite causal link to what is often a compensable event. Therefore, when evaluating possible PTSD with external incentives at stake it becomes necessary to carefully assess causality, intentionality, and motivation as well as traumatic events and symptoms. Furthermore, when incentives are at issue, clinicians must report their opinions outside the therapeutic dyad. This difficult situation demands an objective, thorough, and sensitive clinical evaluation in which clinicians must struggle with the implications of believing or disbelieving their patients' reports, often while feeling awed by the enormity of the reported traumatic events. As the case of Iron Mike illustrates, differentiating malingering from PTSD in the real world is not simple.

James High, M.D.

We argue here that assessing PTSD claims for possible malingering requires sharpening, not discarding, one's clinical sensitivity. As with any other diagnosis, detection of malingering begins with a thorough evaluation of history and symptoms. Recounting an event said to be traumatic is insufficient. A simple listing of symptoms, even if obtained in a well validated structured interview, is not enough. Obtaining an alliance with the patient is essential in determining when breaks in communication occur, when one needs to question further, and in distinguishing between confusion and genuine memory problems versus lack of cooperation. Verbal descriptions also are not enough. Observation of emotional and physical behaviors surrounding communication is essential to determining the meaning and reliability of information. Moreover, unquestioning acceptance of the patient's formulation of the problem is insufficient. Alternative explanations and collateral sources such as records, family, and testing must also be considered. Our experience is that when clinicians are duped by malingerers, their blindness can usually be traced to an important issue they failed to address in the initial evaluation process. The following guidelines are offered with basic principles of good clinical practice in mind. Resnick (1), Pitman et al. (2), and Rogers (3) offer further discussion on a number of these points.

Malingering Guidelines

- An essential safeguard against being duped by a PTSD malingerer is having an index of suspicion for malingering. The clinician's index of suspicion should rise when the patient:
  - does not cooperate with the evaluation. This includes statements of being unable, unwilling, or "forgetting" to perform diagnostic tests;
  - calls attention to his or her distress but is evasive about details of symptoms. The malingerer often appears to relish talking about the trauma but becomes evasive when asked for details of symptoms, while the opposite tends to be true of the PTSD sufferer;
  - shows behavior discrepant with reported symptoms, e.g. claiming to be unable to work because of anxiety and flashbacks but engaging in recreational activities;
  - presents pre-trauma functioning in an over-idealized light;
  - tends to blame all life problems on the trauma and resultant PTSD. Patients with true PTSD tend to avoid treatment, focus on their responsibility-induced sense of guilt, and attempt to appear normal. By contrast, malingerers place their trauma at the forefront and use it to justify their ends.

- Some common misconceptions about malingerers that may obscure the clinician's perceptiveness include:
  - malingerers tend to be men. There is no evidence of gender differences in frequency of malingering.
  - malingerers tend to be sociopaths. Despite the DSM-IV assertion of a connection between sociopathy and malingering, no studies link these two behaviors (3).
  - trauma clinicians can spot a fake story of trauma, and therefore, a convincing story is likely to be true. There is no connection between the vividness and emotional impact of a trauma story and its truthfulness.

- PTSD is unique among psychiatric disorders in that the patient's state of mind at the time of the event is crucial to diagnosis and therefore must be carefully explored in the interview. True PTSD sufferers are able to describe Criterion A peritraumatic horror, helplessness, and/or dissociation. Absence of, or vagueness about, these "state of mind" aspects of PTSD when recounting relatively recent traumatic experiences is therefore suspicious.

- When inquiring about trauma, it is important to begin with non-suggestive questions that encourage patients to tell their stories. Question carefully for details of "B" criteria re-experiencing and don't accept labels. For example, ask what it's like for the patient to "relive" an experience or have a "flashback." There are differences between flashbacks and mere unpleasant memories. These differences must be carefully explored by the clinician. Standardized structured interviews are highly suggestive to malingerers and are primarily useful in situations where malingering is not an issue.

- Malingerers tend to forget "negative" symptoms of PTSD. Carefully check with the patient regarding DSM-IV PTSD "C" criteria such as avoidance of trauma-related activities and detachment from close relationships. Wishing to be likeable and believable, malingerers often assert their deep love and closeness toward family, not realizing this is inconsistent with emotional numbing. True PTSD avoidance serves the purpose of controlling painful symptoms. Malingered avoidance tends to have an external incentive such as enhancing monetary compensation.

- With unsophisticated malingerers, we have had success using the common clinical technique of inserting a rare and unlikely symptom (such as hair pulling or decreased need for sleep) into a series of questions about PTSD symptoms.

- Even sophisticated malingerers may find it difficult to consistently mimic behavioral cues for PTSD such as physical signs of "D" criteria hyperarousal and dissociative "spacing out" when trauma is discussed. Therefore, careful observation of behavioral responses such as staring, startling and somatic reactions when traumatic material is discussed during interview can help to distinguish between a true PTSD sufferer and a malingerer.

- Carlson (4), Briere (5), and Wilson and Keane (6) have published excellent guides for choosing and interpreting tests for PTSD. The MMPI-2 validity scales can detect symptom exaggeration which may support a finding of malingering. However, the F scale is often elevated in acute PTSD sufferers since this scale contains many trauma symptoms. We have found Arbisi and Ben-Porath's (7) recently developed F(p) scale to be extremely helpful in differentiating individuals who are highly disturbed by trauma from malingerers. Self-report measures without validity scales such as the Dissociative Experiences Scale, can also help identify malingering "yea-sayers" if you ask for detailed examples of any symptoms reported.

- It is essential to carefully explore the chain of causality, and consider alternative causes. We have noted earlier that

good clinical practice demands that we not accept unchallenged the patients' hypotheses as to the cause of their problems. Resnick (1) points out that even when the patient has PTSD, providing misleading information about the cause of one's disorder is as much malingering as is reporting false symptoms.

- Ultimately, malingering is not simply a diagnosis of clinical judgement or psychological testing. It is a decision that the patient more likely than not is misrepresenting facts concerning the nature, severity, and/or cause of his or her distress. Therefore, differentiating true from malingered PTSD requires seeking corroboration through collateral sources. Records from medical, military, and legal sources must be obtained. Likewise, partners should be interviewed to corroborate behaviors such as the frequency of night time awakenings, physical activity during sleep, and changes in sexual activity and emotional availability since the trauma.

Discussion

Where does Iron Mike stand in view of these guidelines? The development of his symptoms in a legal context, his intentional neurological symptoms, and his eagerness to recount his dramatic Vietnam story as part of his compensation seeking raised the index of suspicion for malingering. As we have seen, the fact that his psychiatric nurse and later a court reporter were moved to tears when he told his combat story was no guide to the accuracy of his report. Our review of medical records showed no evidence of peritraumatic alteration of consciousness, organic or psychological, following his accident. Also, his post accident MMPI was invalid due to exaggeration. Most importantly, his service records indicated that he had *never* been in Vietnam. Iron Mike malingered his combat and accident-related PTSD and neurological symptoms. An interview with his older brother, however, corroborated chronic, severe physical abuse during his childhood. Thus, it is possible that his conversion symptoms, as well as some of his PTSD symptoms, were valid expressions of genuine trauma. In his case, as in others, the diagnosis of malingering did not rule out the presence of another psychiatric disorder.

Dealing with the possibility of malingering when asked to examine on behalf of a third party is relatively straightforward since the evaluator's role as decision maker is clear. The task of separating true from malingered PTSD arises with greatly increased immediacy and complexity when the patient in treatment seeks to enlist his or her clinician's intervention with outside parties to obtain external incentives such as financial benefits, avoidance of onerous duties and punishments, and obtaining narcotics of questionable necessity. Strasburger et al. (8) point out that clinicians who agree to help in this way must recognize that they have taken on an additional role that may conflict with their therapist role. We agree with these authors that, whenever possible, clinicians should avoid this role dilemma.

When this is not possible, the clinician enters into the dual roles of treatment provider and evaluator. In the role of provider, it is often acceptable to use clinical judgment alone. As an evaluator, however, more than clincial judgment is required. Careful history taking and symptom evaluation then take on a new importance. Validated psychological testing should be obtained. Corroboration whenever possible becomes a necessity. Otherwise clinicians risk colluding with their patients' malingering.

The mere act of requiring that the patient "prove" their PTSD is genuine may irreparably damage the therapeutic alliance. Furthermore, even if you discover malingering there may still be other illness to treat, including PTSD. A judgement that malingering exists may not end the need for treatment. In fact, the frank discussion of the patient's deception may allow the therapeutic alliance to evolve into a more realistic and genuine relationship, a task requiring exceptional skill and sensitivity. Sadly, even when the skill exists and the treatment need is acute, confronting the deception more often irrevocably ruptures the alliance. Iron Mike's psychiatrist attempted to discuss Mike's deceptions in therapy. Mike fired him and continued "therapy" with a less skilled and more gullible clinician.

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NEW DIRECTIONS

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We all take things for granted. Familiarity is one of the major reasons why we do so. For example, we may not realize that the pleasant woman who has occupied the next office for as long as we can remember is a world famous this-or-that, until we learn that she has just received some distinguished award or that she will be featured by the national media or that an old friend in a distant city thinks we are very lucky, indeed, to have her as a colleague.

I'm beginning to wonder whether that may also be the case with the clinical, research and educational programs the Department of Veterans Affairs has developed for PTSD—that they have been taken for granted. Thanks to the vision and determination 15 years ago of veterans and congressional initiatives, the VA has developed the most comprehensive spectrum of PTSD treatment programs in the world, ranging from Vet Centers to PTSD Clinical Teams (PCTs) to a variety of residential and inpatient alternatives. VA researchers have spearheaded the development of new psychological and pharmacological treatments, have established that brain structure and function is altered in PTSD patients, and have made extraordinary discoveries showing how PTSD results from disruptions in major biobehavioral systems that mediate learning, memory, coping, and adaptation. Likewise, VA experts have set the national PTSD educational agenda, figure prominently in any list of influential authors, speakers, and teachers; and have developed some of the most successful training programs in the PTSD field.

Although VA's Undersecretary for Health, Dr. Kenneth Kizer, has continued to express his support for PTSD and other specialized mental health programs, questions continue to be raised by a few VA policy makers whether these remarkable clinical, scientific, and educational advances really provide "value added" for veterans and for the Department of Veterans Affairs. I think they have forgotten what it was like 15 years ago. I think they don't realize what a momentous loss it would be if these programs were to disappear.

From my vantage point within the National Center for PTSD, I can tell you that national and international experts do not take these accomplishments for granted. Within the United States, VA PTSD clinicians and scientists are highly recruited for seats on advisory boards research review committees, and a wide variety of federal (e.g., NIMH, military) academic, professional and community task forces.

What is most striking, however, is the excitement that colleagues from other nations continue to express about the remarkable system VA has established for treatment, research, and education on PTSD. They come to see for themselves so that they can recreate such programs in their own countries. Indeed, several nations following the example of Australia, plan to establish their own national centers for PTSD and have come to us for help and advice. A steady stream of visitors, many of whom are government officials, from Western Europe, Australia, Israel, Kuwait, Japan, Croatia, Canada, and South Africa have come to learn from us, to let us train their professional staff, and to collaborate with us in order to build global networks to advance our field. An outstanding example is the ongoing multi-national effort to reduce stress-related disorders and PTSD among active duty UN/NATO military personnel and among new veterans of such peacekeeping operations.

So there's the irony. As a number of governments as well as colleagues in other U.S. governmental, clinical, and academic settings discover the value of our clinical and scientific achievements, as they recognize how our work with American veterans is applicable to veterans and non-veteran trauma survivors elsewhere, and as they look to VA as the world leader in this rapidly growing field, the Department of Veterans Affairs continues to debate the "value added" of its PTSD programs. VA PTSD professionals continue to work in a context of uncertainty about the future and ambiguous support for its unique and extraordinary spectrum of clinical, research, and educational programs.

During the past few months, I have had the opportunity to consult with the national leadership of Veterans Services Organizations (VSOs). They are very concerned about the future of VA mental health programs in general and PTSD programs in particular. From what their constituents tell them, VSOs are concerned that if VA-based PTSD programs were to disappear, either through budget reduction or reallocation of resources, that veterans with PTSD would be unable to obtain the treatment they need from clinicians with the specialized expertise needed to deliver such high quality services. Based on reports from VSO leaders, veterans are especially worried that if outpatient treatment were vouchered to community mental health or to private sector outpatient clinics, that veterans would be unable to access clinicians with the sophistication and experience to treat the unique psychological problems that result from military action and war zone trauma.

I share their concerns. Like many of you, I hope that veterans will never be faced with this problem. I hope that the remarkable spectrum of VA clinical, research, and educational programs can survive the serious budgetary pressures faced by top VA leadership and that we can continue to serve our veteran clientele. I also hope that by preserving these programs and by recognizing their "value added" to the Department of Veterans Affairs, that VA can maintain its global leadership in the understanding and treatment of stress and trauma-related disorders.

WOMEN AND TRAUMA: A CLINICAL FORUM

Marie B. Caulfield, Ph.D., & Annabel Prins, Ph.D.

Deficits in Personal Resources in Survivors of Child Abuse: Targets for Clinicians

Marie B. Caulfield, Ph.D. & Kiban Turner, Ph.D.

Adult survivors of physical and sexual child abuse may present with specific difficulties related to the developmental and interpersonal nature of their trauma. Clinically, many clients presenting with these difficulties will be women, due to the high rate of child abuse of girls, as well as the higher number of women seeking mental health care. Abusive and neglectful environments may impact on the development of a wide range of personal resources necessary for establishing and maintaining good social relationships. In this article, we will dis cuss three personal resources: empathy, social problem-solving, and locus of control.

Empathy

Survivors of child abuse often describe difficulty in experiencing empathy for others. Research suggests that because neglectful and abusive parents do not model empathy for their children, abused children may not learn perspective-taking, and thus do not have the skills necessary for empathy. Evidence suggests that good relationships with important others, including non-abusive family members, teachers, and coaches may help children develop skills that were not fostered in their homes.

Relationships with clinicians can provide opportunities for adult survivors to learn and practice empathic behaviors. Trauma survivors often are unable to have empathy for themselves, especially with regard to their abusive experiences. They may blame themselves or minimize the emotional impact of their experience. An empathic response from the therapist can help the client view her life with compassion and it helps to foster a safe environment in which the survivor can discuss difficult experiences and feelings. The therapist can foster perspective taking by asking the client questions about what the she imagines other people are thinking. Psychoeducation on the impact of child abuse on empathy can also help the survivor understand why she may respond to others with indifference or anger rather than empathy in certain situations.

Social Problem-Solving

Children who grow up in abusive or violent homes often show deficits in social problem-solving as adults. Because violence and coercion were often used to resolve problems in their families of origin, survivors of these abusive situations may not have developed rational, non-violent means for solving problems. As a result, survivors may arrive at solutions to problems impulsively, and they may apply solutions that are harmful to themselves or others.

Clinicians can model appropriate social problem-solving by "thinking out loud" about challenging interpersonal situations faced by the client, and, where appropriate, through self-disclosure of examples from the therapist's own life. Some child abuse survivors may have extreme deficits in this area, with a limited repertoire of responses to interpersonal interactions. In these cases, even minor interactions within the therapeutic relationship can be helpful in teaching the client new patterns of relating. Child abuse survivors also may show a tendency towards black-or-white thinking with regard to interpersonal situations (e.g., the other person is either all bad or all good.) It may be beneficial for clinicians to view this extreme thinking as a skill deficit rather than as an intractable personality characteristic.

Locus of control

Abusive environments do not allow for learning a sense of internal control over one's environment because abuse often happens unpredictably. For example, the pattern of physical abuse experienced from an alcoholic parent might teach a child that the world is an unsafe, erratic place over which the child has no control. As an adult, this learning might generalize to a range of social relationships, with the survivor feeling that relationships are unsafe and impossible to negotiate. The child abuse survivor may feel helpless as an adult and be incapable of fully asserting autonomy. This may be compounded for women, many of whom have been socialized to be less assertive than men.

Consistency and predictability within the therapeutic relationship are important for providing child abuse survivors with a sense of safety. It is crucial that therapists communicate directly that the client and the therapist share control within the therapeutic relationship. For example, therapists should invite the client to signal for a break if they need one, check in with the client about the specifics of the therapy room (e.g., do they want the door cracked open, the shades drawn, etc.), and encourage them to voice any concerns or complaints they may have about the therapist or therapy. In work with trauma survivors, it is important for the therapist to balance the need to address traumatic material in therapy with teaching the client to pace their disclosures in order to maintain a sense of control.

These areas of social competence are important targets for work with trauma survivors, particularly those who experienced chronic interpersonal abuse during childhood. In addition to the clinical strategies discussed above, clinicians may find it helpful to incorporate techniques from cognitive behavioral treatments that address these deficits. Deficits in these areas can compromise the survivor's relationships with others, preventing the survivor from functioning effectively at work, socially, or as a parent or spouse. With extreme deficits, the survivor may become involved in an abusive situation as an adult. By addressing these areas in treatment, we can help clients build stronger, more reciprocal relationships with others.

TRANSCEND: A PROGRAM FOR TREATING PTSD AND SUBSTANCE ABUSE IN VIETNAM COMBAT VETERANS

BEVERLY DONOVAN, PH.D. & EDGARDO PADIN-RIVERA, PH.D.

Beverly Donovan, Ph.D.

Over the past decade, there has been growing recognition that dual problems of Post-Traumatic Stress Disorder (PTSD) and Substance Abuse (SA) among combat veterans seeking treatment is quite high. Incidence estimates suggest the rates of SA among persons with PTSD may be as high as 60-80%, while rates of PTSD among substance abusers is between 40-60% (1-2). Surprisingly, there have been few studies in the literature that indicate effective treatment outcomes for veterans. At the VAMC in Brecksville, Ohio, a program for chemical abusing PTSD patients called Transcend was developed six years ago to fill this void.

Program Description

Transcend is a 12 week partial hospitalization program for Vietnam veterans diagnosed with PTSD and SA disorders. Beyond diminishing PTSD symptoms and promoting an addiction-free lifestyle, other goals of the program include developing a mastery of impulses, acceptance of responsibility for change, diminishing shame, nurturing self-acceptance, and augmenting self-efficacy beliefs. A treatment manual details therapeutic themes, goals and objectives of each session, and describes specific interventions for each session across the 12 weeks. The manual includes both a Patient Workbook and Therapist Guidelines and is available to clinicians upon request from the National Center for PTSD at Menlo Park/Palo Alto.

The Transcend program format mandates that all clients complete a primary SA rehabilitation program within six months of beginning Transcend. A maximum of ten clients enter the program as a cohort and remain together throughout the three months of primary treatment. The protocol is logically divided into group cohesion development and skills development (first six weeks) and trauma processing (weeks seven to twelve). Treatment is structured around fourteen hours of group therapy each week with addiction recovery counseling interwoven throughout. Patients submit weekly and random urine checks to verify they are drug free.

The interventions strategies in Transcend derive from an integration of three process goals. The first is to develop a therapeutic alliance that establishes the client's responsibility for change; the second is to instill a dedication to self-exploration; and the third is to engage clients in new, positively reinforcing behaviors. A basic tenet of the program is that there is no real change without behavioral change. For the therapists, this means taking responsibility not just for teaching clients new skills, but also emphasizing the need to act on newly learned behaviors, coaching them in individual sessions, helping them maintain new skills by providing reinforcement episodes, and instructing them in self-reinforcement.

Peer support is considered vital in helping dismantle long entrenched patterns of isolation, violence and substance abuse (3). Hence, group process and feedback are considered among the most potent intervention tools of the program. From the beginning, therapists teach, model, and reinforce skills conducive to building supportive relationships. They also strive to generate a group atmosphere of non-judgmental listening, empathic responding, active participation and self-responsibility (4-5). Specific ways to communicate effective feedback are taught early and consistently reinforced.

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One of the program's primary assumptions is that veterans who come for treatment are trapped by ambivalence and fear. Hence, the structure of the program has a sequencing of content that allows for a gradual emergence into traumatic material. In order to address their ambivalence, the early weeks of treatment are devoted to developing a sense of group identity and interpersonal safety. The sequential structure incorporates skill building exercises (such as problem solving, anger management, and relaxation training) which allow clients to develop a repertoire of calming techniques so they do not become overwhelmed by the emotional work inherent in trauma processing (6). Early sessions focus on enhancing an understanding of the interconnection of PTSD and addictive behaviors, emphasizing similarities among group members, reinforcing empathic responses, and introducing new interpersonal coping skills. Treatment then proceeds to an exploration of pre-trauma emotional relationships, including childhood issues and experiences. The emphasis is not on uncovering childhood traumas, but on incidents that reveal vulnerabilities and emotions, good and bad. Finally, the last six weeks are devoted to processing war zone trauma, promoting cognitive restructuring and self-acceptance, strengthening self-esteem, diminishing pathological shame, and continuing to build relapse prevention strategies. The culmination of this process is facilitated by a group trip to the Vietnam Memorial in Washington, D.C., during the eleventh week of treatment. We have designed rituals for the trip to "the Wall" which are specifically designed to reduce survivor guilt and pathological shame. Although these rituals have maximum emotional effect when performed at the wall, they could be creatively incorporated into treatment by any treatment team.

Specific therapeutic interventions attempt to balance directive teaching and client-centered insight with a strong emphasis on active learning. Group discussion, readings, and written exercises are used to encourage members to ask questions, scrutinize their beliefs, and engage in dialogues with one another. Facilitators encourage members to challenge negative

self-beliefs and self-defeating behaviors. Clients are required to directly confront SA lifestyles and examine ways addictive behaviors destroy self-worth and hope. Uncovering and examining defenses against pain, anger, vulnerability, and grief is a vital aspect of group process. Clients are enjoined in group to label and express emotions with the suggestion that as intense feelings are brought into conscious awareness their unconscious influence on behavior will diminish.

Intervention Examples

An intervention we have devised called "A letter to your father" provides an example of a group cohesion-building exercise. During the fourth week of treatment, each client writes a letter to his or her father. This assignment is carried out regardless of whether or not the father is alive. These letters need not be sent, but are portrayed as a way to allow clients an opportunity to express emotional vulnerability and to understand how childhood experiences may influence behaviors or reactions. Often a client will be asked to write more than one letter if some other male figure greatly influenced his childhood experiences. In these letters, each group member is asked to write about things his father did that he is thankful for, things that made him angry or sad, things he resents or regrets, and ways he wishes his relationship with his father had been different. The letters are then read over the course of two group sessions. Group members have the opportunity to demonstrate empathic listening, provide emotional support, and reinforce the benefits of expressing emotions. The following is an example of what benefits can be gained from this exercise.

Ray M. wrote a letter to his biological father, who had been both an alcoholic and abusive. In the letter, he recounted specific incidents of abuse that included being forced to smoke a whole cigar when he was five years old as a punishment, watching his father kill his pet kittens with a knife, being terrified at age seven when his father took him along on an armed robbery attempt, and having to stand helplessly by as his father beat his mother. His feelings regarding these events were affirmed by fellow group members who were shocked and appalled by what they heard.

A few weeks later, Ray described his warzone traumatic experiences. His unit had engaged in a number of search and destroy missions in villages. Ray's commanding lieutenant instructed the soldiers to rape and then do "whatever else" they wanted with the women. Although most of the company complied, Ray refused. He was taunted by the lieutenant for his noncompliance and implications were made that he was homosexual or effeminate. His rage continued to build towards this officer until during one moment of humiliation in front of his peers, Ray grabbed his rifle and shoved the bayonet through the lieutenant's abdomen. He later greatly feared that he may have attacked the officer because he was "*really a coward and secretly hoped to have to leave the warzone.*" During the processing of this event, group members helped Ray explore his rage. He was given the insight that his anger at the moment of attack wasn't directed solely towards the lieutenant but was also fueled by and directed towards his father who had humiliated him and forced him to stand helplessly by while he beat Ray's mother. This connection between warzone experiences and childhood events began the process of self-forgiveness, and allowed Ray to feel more compassion towards himself and consequently to become less judgmental of others.

In contrast to treatments for combat veterans that do not employ trauma processing, we believe it an essential part of the recovery process (7). However, our conceptualization is not that this process be enlisted solely to desensitize the veteran, but rather the emphasis is placed on two major intervention principles. One is that having others witness and empathize with the traumatic events and emotions surrounding them is healing in and of itself. The second is that trauma processing must incorporate cognitive restructuring of the meaning of these events and a more compassionate understanding of why decisions were made during the duress of warfare and must promote self-acceptance and self-forgiveness (8).

In the Transcend treatment protocol, each client is required to spend time preparing for trauma processing by writing a detailed account of his war zone experiences. He is then given a three hour session devoted to "telling his story" (relating war zone trauma). The following is an example of how this trauma processing may facilitate change.

John D. began his session by relating in a very unemotional manner what had happened to him when his unit was ambushed. He mentioned that a good friend, Alan B., died during the firefight, then quickly tried to move to the description of other events. He was slowed down by questions from both therapists and fellow group members who sought details regarding how this man died and his importance to John. Questions included: *"How did he die? Did you see him get hit? Where was he wounded? What did you see when you looked at him? What do you think about when you recall his death? How long had you known him? What was he like?"*

Asking these questions helped elicit an issue of survivor guilt and eventually promoted movement towards grief resolution. John clarified that he had refused to take an assignment as radio operator because he knew it was particularly dangerous. His friend, Alan, however, later consented to this job. John was mad at this friend for accepting the assignment, but he also feared that Alan died because he had refused it.

The trauma processing sessions always allow time for structured feedback from other group members. The importance of this cannot be emphasized enough. In this case, ideas for reframing were provided by fellow combat veterans with feedback like, "*John, it wasn't your fault he died. I never would be a radio man either. Shit happens in firefights and no one can stop it. He was lucky to have someone who really cared about him like you did.*" and *"I know what it feels like to lose a good friend. I know why you feel guilty. My friend walked point for me on one mission and died. I always felt like it should have been me."*

Since there is an entrenched defense against feeling painful losses, a gestalt-like procedure was used to assist in emotional expressiveness. John was asked what he would want to say to Alan if he walked in the door right now. At this point John began to sob and express more of his emotions. As if talking to his lost friend, he said, *"Why did you take that job? I told you it would get you killed. I really felt bad when you died—I really missed you. I know you will understand why I couldn't even stop and make sure you were dead. I'm glad you haven't suffered all these years like I have. I'm glad you weren't an invalid for years. You were a real hero in my book and you always will be."*

After this, feedback again provided an opportunity for group members to actively participate and demonstrate empathic responding. When asked to describe how he felt, John said he had never told anyone

how guilty and sad he had felt after Alan died, and affirmed that he felt as if a big weight had been lifted from his shoulders. To continue the grief work around this incident, John was asked to write a letter to Alan saying all the things he had related during the group session. He then took the letter on the group trip to Washington, DC and left it at "the Wall". During the trip, John made a pledge regarding life changes he was willing to make so he could honor the memory of his friend rather than punish himself for having survived.

Supplemental Activities and Aftercare

During the 12 weeks of primary treatment, the core structure of group psychotherapy is enhanced by a number of additional activities designed to restructure the veteran's lifestyle and augment recovery. To help develop healthy ways to relieve tension and anxiety, each client is required to engage in a structured water therapy program three times a week. Each must also participate in a community service project for at least two hours weekly, spending time with elderly, nursing home veterans or volunteering with a local social services organization. These supplemental activities help break down established isolating patterns, re-establish self-esteem, increase a sense of self-efficacy and move clients beyond a predominant victim identification. The structured exercise program and daily relaxation training helps relieve tension in a natural manner and assists clients in developing habits which can lead to permanent lifestyle changes.

Coordinated outpatient aftercare is viewed as crucial to sustain treatment gains (7-10). Hence, clients are required to attend aftercare group once a week for an hour and a half after completion of the 12-week program and are encouraged to remain in aftercare for anywhere from six months to two years. PTSD symptom management and relapse prevention education continue to be emphasized throughout this second phase and clients are strongly encouraged to attend additional addiction recovery meetings each week.

From inception, Transcend incorporated a program evaluation component which looked at both effectiveness and efficacy. Outcomes show significant change in PTSD symptomology on the Clinician Administered PTSD Scale (CAPS) and a very low chemical abuse relapse rate as measured on Addiction Severity Index (ASI) follow-ups. Data indicates there was a significant decrease in overall CAPS scores from pre-treatment to post-treatment. In addition, there were significant decreases in the overall Avoidance scores (both Frequency and Intensity measurements) and in the Arousal Frequency scores. Furthermore, these gains have been maintained at six month and one year follow-up testing. Intrusive symptoms were diminished but the change failed to reach significance.

As to costs, veterans are housed in a Domiciliary residence, rather than an inpatient unit. Staff engaged in the program has been kept at two therapists and one part-time interviewer who is not part of the treatment staff. This has allowed for efficient, cost-effective treatment; moreover, the small staff greatly facilitate the building of rapport and better ensures that old patterns of isolation subside. Thus, the entire program is maintained at very low cost.

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This change will help ensure that we will have the funds to continue keeping you informed about trauma-related topics important in clinical practice and helping to bridge the gap between scientists and practitioners. We will continue to report on progress in assessing and treating post-traumatic stress disorder.

We also will continue the *Clinical Quarterly's* regular columns exploring new directions in the field and issues specific to women's care.

VA employees will continue to receive the *Clinical Quarterly* at no cost. If you're not employed by the VA, make sure you don't miss a single issue of the *Clinical Quarterly*. Just complete and return the order form to begin your annual subscription today.

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NC-PTSD EDUCATION & SUPPORT SERVICES

PTSD Assessment Library

Available upon request are selected instruments from our library of assessment and program evaluation tools (with accompanying articles), together with templates describing over 100 trauma-related measures courtesy of Beth Stamm, Ph.D., and Sidran Press. Telephone (650) 493-5000 ext. 22477.

PTSD Article Library

A helpful set of key articles on aspects of PTSD is available to VA or Vet Center clinicians free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Video Library

The Menlo Park Education Team maintains a small videotape lending library exploring topics related to PTSD diagnosis, evaluation, and treatment. Videotapes may be borrowed free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Program Liaison and Consultation

The Menlo Park Education Team can help VA health care professionals locate needed resources. Services may include assistance in locating relevant articles, locating resource persons, or problem-solving. Staff are available to consult in the areas of PTSD Diagnosis and Treatment, Program Development and Design, Women and Trauma, Relapse Prevention, and with other PTSD-related concerns. Telephone (650) 493-5000 ext. 22977.

National Center for PTSD Web Page

The NC-PTSD Home Page provides a description of activities of the National Center for PTSD and other trauma related information. The world wide web address is: *http://www.dartmouth.edu/dms/ptsd/*

PILOTS Database

PILOTS, the only electronic index focused exclusively on the world's literature on PTSD and other mental health consequences of exposure to traumatic events, provides clinicians and researchers with the ability to conduct literature searches on all topics relevant to PTSD. *http://www.dartmouth.edu/dms/ptsd/PILOTS.html*

NC-PTSD Research Quarterly

The *Research Quarterly* reviews recent scientific PTSD literature. Telephone (802) 296-5132 for subscription information.

Disaster Mental Health Training and Consultation

Education staff provide training in disaster mental health services, including team development, interfacing with other agencies, on-site and off-site interventions, debriefing, and psychoeducational and treatment interventions with disaster survivors and workers. Telephone (650) 493-5000 ext. 22494 or email: *bhh@icon.palo-alto.med.va.gov*

Conferences and Training Events

The Menlo Park Education Team provides consultative support for the development of training in PTSD. Services include assistance in finding faculty and designing program content. Telephone (650) 493-5000 ext. 22673.

Clinical Training Program

The Education and Clinical Laboratory Education Division for the National Center for Post Traumatic Stress Disorder at the Palo Alto CA VAMC, in collaboration with the VA Employee Education System offers a Clinical Training Program (CTP). The training program is approved for 35 Category 1 CEUs for physicians, psychologists, social workers, and nurses.

Each year we welcome many mental health professionals from across the United States and from around the world. Most clinicians who enroll in the program have a working knowledge about treating the effects of trauma and PTSD and are looking to upgrade their clinical skills. The CTP offers a broad range of educational activities including:

* **Lectures**
* **Clinical consultation**
* **Clinical observation of group treatment**
* **Group discussions facilitated by staff**

Specific training topics include warzone trauma group treatment, treatment of women veterans, treatment of sexual assault related PTSD, relapse prevention, cross cultural treatment issues, assessment and treatment of families, disaster mental health services, cognition and PTSD, assessment of PTSD, and psychiatric assessment.

Training programs are scheduled for a minimum of one week, though longer programs are available if the applicant can justify an extended stay. Programs are scheduled nine times per year, generally on the third week of the month.

At present time, funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or VA Employee Education System. For more information, or to request an application, please email: *jir@icon.palo-alto.med.va.gov*, or call FTS 700-463-2673, or commercial number 650-493-5000, ext. 22673.